La Clínica
a californiahealth+ center
PO Box 22210 • Oakland, CA 94623
www.laclinica.org

PARENTAL CONSENT FOR SCREENING AND/OR GROUP PARTICIPATION IN COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

Dear Parents,

We have found that students who have experienced stressful situations as victims or witnesses often suffer from a unique kind of stress, called traumatic stress. The effects often show up in children who do not want to go to school because they are afraid, and sometimes they may have a hard time concentrating in class. Their grades may begin to suffer, and they may begin have some behavioral problems in school.

We would like your permission to ask your child some questions about whether he or she has been a victim or witness of violence in the school or neighborhood. We will not be asking questions about personal issues such as home or family. Like screening for eye problems, this screening helps us to learn if your child is experiencing learning problems due to violence. You may see a copy of all the questions by contacting _____ at _____.

If you accept and your child meets eligibility for the group, we will offer your child a ten-week group, focused on helping her/him to process the experience and reduce stress. The group also helps develop problem solving skills to increase peer interaction and positive choices.

In signing the bottom of this form, you as the parent or guardian are indicating your understanding that information regarding your family will be confidential with the exception of situations that may be harmful to the health and safety of others, including yourself and your children. It is your right to accept, refuse, or stop services at this time.

All of the information will be used to try to improve your child's academic success.

Thank you for your cooperation and support.

_____ _____
Integrated Behavioral Health Clinician Telephone Number

_____ _____
Principal Telephone Number

❑ I accept ❑ I decline ❑ Please call me, I have a question or concern

_____ _____
Student Name Student Date of Birth

_____ _____
Name of Parent/Guardian Telephone Number

_____ _____
Signature of Parent/Guardian Today's Date

***** Please return to:** _____ **no later than:** _____

Consent Form also available in Spanish and Chinese.

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❑ TECHNICLINIC ❑ SAN LORENZO HIGH HEALTH CENTER
❑ TIGER CLINIC ❑ ROOSEVELT HEALTH CENTER ❑ HAWTHORNE CLINIC
❑ HAVENSCOURT HEALTH CENTER ❑ YOUTH HEART HEALTH CENTER
❑ FUENTE WELLNESS CENTER ❑ OTHER: _____

PATIENT NAME _____ SEX: M F
MR# _____ DOB: _____
PRIMARY PROVIDER: _____ DATE: _____
SCHOOL: _____

CONSENT FOR MINORS

Best number where we can reach you: _____ ❒ Home Phone ❒ Pager ❒ Cell Phone
OK to send an appointment reminder by text message? ❒ Yes ❒ No ❒ At different number: _____
Standard Text Messaging Rates May Apply

By law in California I can receive certain services without consent from my parent or legal guardian. These services include:

- ❖ diagnosis and treatment of sexually-transmitted infections
- ❖ pregnancy testing and referrals
- ❖ prescriptions for birth control (e.g., condoms, the pill)
- ❖ alcohol and drug abuse counseling or treatment
- ❖ mental health assessment and crisis intervention/counseling
- ❖ treatment for medical emergencies

Our priority is to protect your health and safeguard your legal rights. Please read the following section carefully and sign below.

ABOUT CONFIDENTIALITY

I understand that information about my health and health care will be kept confidential. However, I understand that La Clínica staff may share or be required to share this information in the following situations:

1. Staff within La Clínica may share information about my health or health care with one another in order to best help me.
2. To bill health insurance programs (e.g., Medi-Cal or Family PACT).
3. Staff may share information about me or my health care with researchers or evaluators, but this information will not be attached to my name.
4. If they judge that I am at risk of hurting or killing myself, La Clínica staff must report this to the police and will probably tell my parent(s) or legal guardian.
5. If I have threatened to physically hurt or kill another person, they must report this to the police and to the person(s) involved.
6. If I share information about physical, sexual or emotional abuse or neglect, they must report this to Social Services and/or the police.
7. If I am under 16 and having sex with someone 21 or older; or if I am under 13 and having sex with someone 14 years or older, they must report this to CPS and/or the police.
8. If I come to La Clínica drunk, high or otherwise under the influence and the staff think I am at risk of hurting myself or someone else, they might call my parent or guardian to help make sure I'm safe.
9. If I bring weapons or other dangerous objects into La Clínica.
10. If I sign a consent to release this information to another health care provider.
11. If a judge requires La Clínica to share this information with the courts.
12. La Clínica staff may confirm with my teacher that I was in La Clínica to clear my absence, but not why I was there.
13. If I test positive for certain sexually-transmitted infections, I understand that La Clínica will need to report this information to the County Health Department, and that the County MAY attempt to contact me.

By signing below, I acknowledge that I:

- ❒ have read and understand the information described above, including the conditions about confidentiality.
- ❒ agree to fill out a Client Survey that asks some personal questions about me.
- ❒ verify that I have received a copy of La Clínica's Notice of Privacy Practices.
- ❒ have received a copy of this consent form.
- ❒ verify that I have received a copy of La Clínica's Patient Rights & Responsabilities.

_____ SIGNATURE

_____ DATE

Consent Form also available in Spanish

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PARENT/ LEGAL GUARDIAN CONSENT FORM

SCHOOL-BASED HEALTH CENTERS

❑ **TECHNICLINIC**
Oakland Technical High School Health Center
(510) 450-5421

❑ **TIGER CLINIC**
Fremont High School Health Center
(510) 434-2001

❑ **ROOSEVELT HEALTH CENTER**
Roosevelt Middle School
(510) 535-2893

❑ **SAN LORENZO HIGH HEALTH CENTER**
San Lorenzo High School
(510) 317-3167

❑ **HAWTHORNE CLINIC**
Urban Promise Academy and World & Achieve Academies
(510) 535-6440

❑ **HAVENSCOURT HEALTH CENTER**
Roots, Coliseum College Prep Academy
(510) 639-1981

❑ **YOUTH HEART HEALTH CENTER**
La Escuelita Education Complex
(510) 879-1568

❑ **FUENTE WELLNESS CENTER**
Reach Ashland Youth Center
(510) 481-4554

Youth's Name: _____ School: _____ Birthdate: _____

Name(s) of Parent/Legal Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ❑ Male ❑ Female ❑ Other Social Security # (if applicable): _____

Ethnicity: _____ Language: _____

Type of Insurance: ❑ *None* ❑ *Medi-Cal* ❑ *Alameda Alliance* ❑ *Blue Cross* ❑ *Kaiser* ❑ *Health PAC* ❑ *Other Private:* _____

Healthcare Provider: _____ Phone No. _____ ❑ No current Medical Provider

I/We have read and understand the services offered at the School Health Center as described below. I/We understand that the services authorized by my/our signature on this form are limited to routine health services and treatment which may include, but are not limited to:

1) Diagnosis/treatment of minor and acute illnesses; first aid for minor injuries

2) Assistance with chronic (on-going) illnesses

3) Physical examinations for well-checks, sports, or pre-employment clearance

4) Immunizations

5) Laboratory services

6) Vision services that include eye exam and prescription eye glasses – AT PARTICIPATING SITES ONLY

7) Over-the-counter and basic prescription medications

8) Mental/Behavioral Health Counseling

9) Education concerning: nutrition; drug and alcohol abuse prevention; violence prevention; mental health; sexually transmitted disease and pregnancy prevention

10) Dental screenings and treatment – **AT PARTICIPATING SITES ONLY**
During school-wide dental screenings, a licensed dental professional will examine your child's teeth and determine if they are in need of dental care. This screening does not include x-rays and does not replace an in-office dental examination. If a problem is detected, you will need to make a follow-up appointment with your dental provider; or the School Health Center staff may be able to assist you with a dental appointment on-site.

- I would like my child to participate in the school-wide dental screenings: ❑ Yes ❑ No
- I would like my child to receive dental services at the School-Based Health Center: ❑ Yes ❑ No

11) Referrals for health services which cannot be provided at this clinic

12) Other services, including fitness training, group exercise classes and referrals to social services including legal assistance

Continued on page 2

Please note: California State Law (California Family Code 6924-6929) permits for the provision of certain services to adolescents, 12 years and older, with or without parental consent. These services include: diagnosis and treatment of sexually transmitted infections, HIV counseling and testing, pregnancy counseling and testing, contraceptives, referrals for prenatal care, and mental health counseling in situations specified by the law.

Please list any services offered at the School Health Center you **do not want** your child/ward to receive:

_____

_____

I/We understand that this consent covers only those services provided at the School Health Center and no other private or public health facility. I/we hereby authorize a physician and other professional Health Center staff to provide necessary and/or advisable treatment for my daughter/son/ward. This student has my/our permission to receive all services offered at the School Health Center, except those that I/we have specifically excluded above. Students may be asked to register for Medi-Cal at the Health Center. In some instances family income may be a factor in determining eligibility; eligibility may depend on the type of medical or mental health service utilized by the student.

Medical records will be kept confidential. However, I/we acknowledge that the services for my child's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing her/him.

PARTICIPATING IN A COUNTY-WIDE EVALUATION OF SCHOOL-BASED HEALTH CENTERS

In order to improve our services, we are participating in a County-wide evaluation of School-Based Health Centers. The evaluation is being conducted by the University of CA, San Francisco (UCSF). As part of this evaluation, we collect information on the students who use our services. This information is shared with UCSF in aggregate (group) form without names or personally identifying information. We will not share your child/ward's personal information with the evaluators without your permission. By signing this form, you are agreeing to your child/ward's participation in this evaluation.

By signing below, you are consenting to the following:

I, parent/legal guardian below, authorize the School District to grant La Clínica de La Raza, the on-site provider at my child's school authorization to review my daughter/son/ward's student records. La Clínica de La Raza agrees not to disclose the student's records to any other person or entity without first obtaining my written permission.

I understand that La Clínica de La Raza may share my child's information with my child's provider for the purpose of medical evaluation and treatment. This consent form will remain in effect until this student's enrollment terminates, or until I/we revoke this contract in writing.

_____ _____

(Signature) Parent/Legal Guardian Date

_____

Printed Name

Please call the phone number listed on front of this form if you have any questions.

Consent Form also available in Spanish, Chinese, Cambodian, and Vietnamese.